

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045182  
STATE FILE NUMBER

FILED DEC 16 1958 Registration District No. 282 Primary Registration District No. 4424 Registrar's No. 141

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Polk</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Polk</b>                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Humansville</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>Humansville</b> <sup>0840</sup><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Big Springs Rest Home</b>  |  | Length of stay in lb<br><b>73 years</b>   | d. STREET ADDRESS (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Alice Amanda Aker</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>12 5 1958</b>   |
| 5. SEX<br><b>Fe</b>  | 6. COLOR OR RACE<br><b>Wh</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/5/1869</b>  |
| 9. AGE (In years last birthday)<br><b>89</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Indiana</b>   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13a. FATHER'S NAME<br><b>James Walker</b>   |  |
| 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Sanders</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>John W.</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>--</b>  | 17. INFORMANT Address<br><b>Mrs. Lela Robertson, Humansville, Mo.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b>  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE   |
| 21. I attended the deceased from <b>Oct. 58</b> to <b>Dec. 58</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>12/2/58</b><br>Death occurred at <b>11:00</b> P. on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>R. A. Robinson M.D.</b>   |  | 22b. ADDRESS<br><b>Humansville, Mo.</b>   | 22c. DATE SIGNED<br><b>12/6/58</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>12/7/58</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Humansville Cemetery</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>Humansville, Mo.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Beckwith Funeral Home, Humansville, Mo.</b>   |  | 25. DATE RECD. BY LOCAL REG.<br><b>12-11-1958</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Ralph Gordon</b>   |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *O. H. Beckwith* .....

Licensed Embalmer No. *3937* .....

P. O. Address *Humansville,* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.